State of California
Department of Industrial Relations
**DIVISION OF WORKERS' COMPENSATION**
**455 Golden Gate Avenue, 9th Floor**
**San Francisco, CA 94102**

# NOTICE OF EMERGENCY REGULATORY ADOPTION

## Finding of Emergency and Informative Digest

**Subject Matter of Regulations: Workers' Compensation – Official Medical Fee Schedule – Services Rendered on or after January 1, 2004**

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in him by Labor Code Sections 59, 129, 129.5, 133, 5307.1, 5307.3, and 5318 proposes to adopt Article 5.3 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9789.10. This action is necessary in order to implement, on an emergency basis, the provisions of Labor Code Section 5307.1, as amended by Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004).

### Finding of Emergency

The Administrative Director of the Division of Workers' Compensation finds that the proposed regulations attached hereto are necessary for the immediate preservation of the public peace, health and safety or general welfare.

### Statement of Emergency

The containment of medical costs in the workers' compensation system is critical for the future of California. The cost of medical payments under the State's workers' compensation program is increasing at a rate much than a national index of general health care costs. According to the Workers' Compensation Insurance Rating Bureau, the average estimated medical costs per indemnity claim in California's workers' compensation system rose from $8,781 in 1992 to $31,120 in 2002, an increase of 254%. In contrast, medical prices nationally have risen only 49% during that same period. Claims Administrators have paid physicians almost $2.1 billion for services rendered to injured workers in 2002, compared to $1.1 billion in 1995, an 86 percent increase. Hospitals were paid $1.1 billion for in services 2002, a 132% increase over the $485 million paid in 1995. More dramatically, payments to chiropractors have increased by 126% percent, from $104 million in 1995 to $235 million in 2002.

The rise in costs has adversely affected California businesses. According to a recent survey conducted by the California Chamber of Commerce and the California Business Roundtable, the business community believes that workers' compensation insurance is the largest single cost problem associated with doing business in California. The Rating Bureau reports that insurance premiums for California employers have increased from $5.8 billion to $14.7 billion, or 153%, between 1995 and 2002. As a result of escalating costs, 27 workers' compensation insurance

companies have gone bankrupt.

In response to this widely-acknowledged crisis, the Legislature has amended Labor Code Section 5307.1 in Senate Bill 228 (Chapter 639, Statutes of 2003, effective January 1, 2004) to radically change the manner by which health care providers are compensated for medical services rendered in cases within the jurisdiction of the California workers' compensation system. Under the amended statute, the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system or 100 percent of the fees prescribed in the relevant Medi-Cal payment system. The statute also provides that for the Calendar Years 2004 and 2005, the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by 5 percent. The amended statute is designed to expediently limit the costs of medical care for injured workers and streamline medical billing procedures.

Proposed Sections 9789.10 and 9789.11 implement subdivision (k) of amended Labor Code § 5307.1. This subdivision requires that for the Calendar Years 2004 and 2005 the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent. While the Administrative Director has discretion to reduce the fees for individual medical procedures by amounts different than five percent, in no event can the fee for a procedure be reduced to an amount that is less than that paid by the current Medicare payment system for the same procedure.

The statute is not self-executing; it does not define "physician services" nor does it outline the manner by which the 5% reduction shall be imposed. In the absence of clarification and guidance, neither health care providers nor payors will be able to determine which services rendered on or after January 1, 2004 are "physician services," thus subject to a 5% reduction, or which services are subject to payment under the relevant Medicare payment system. Without an immediate interpretation from the Division of Workers' Compensation, medical billing disputes will increase and payments for otherwise necessary medical treatment procedures will be unduly delayed. Further, there will be an upsurge of litigation before the Workers' Compensation Appeals Board, straining that agency's already overextended resources, over the question of whether a 5% reduction was appropriately applied to a fee for a medical procedure.

Proposed Sections 9789.20 through 9789.24 set forth the general information, definitions and payment schedule for the Inpatient Hospital Fee Schedule section of the Official Medical Fee schedule. Labor Code § 5307.1, as amended by SB 228, provides that all fees shall be paid in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. The current Inpatient Fee Schedule (set forth at 8 C.C.R. §§ 9790.1 and 9792.1) does not comply with the requirements of Labor Code § 5301.7. Furthermore, the statute is not self-executing. Although amended Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule. The proposed regulations set forth which general rules and which special rules from Medicare apply to

inpatient medical services. If proposed Sections 9789.20 through 9789.24 are not in effect on January 1, 2004, there will be a substantial likelihood of disputes between the providers and payers regarding the maximum amount allowable on every workers' compensation inpatient hospital fee for services provided on or after January 1, 2004 until the time regulations are approved. The emergency adoption of the proposed regulations is needed to prevent disputes and litigation, and to provide clarity regarding the maximum payment for inpatient medical services.

Proposed Sections 9789.30 through 9789.38 set forth the definitions and fee schedule governing the payment of medical services provided by outpatient hospital departments and ambulatory surgical centers. Labor Code § 5301.7, as amended by SB 228, provides that all facility fees for services provided by outpatient hospital departments and ambulatory surgical centers shall be paid in accordance with Medicare's Hospital Outpatient Prospective Payment System, and that the maximum reasonable fees for outpatient facilities fees shall be 120 percent of the fees paid by Medicare for the same services performed in a hospital outpatient department. Currently, there is no fee schedule in place regulating outpatient or ambulatory surgical center costs. Labor Code § 5301.7 requires that the outpatient hospital department and ambulatory surgical center fee schedule be effective January 1, 2004. The proposed regulations set forth such a fee schedule. If the proposed regulations are not in effect on January 1, 2004, there will be no fee schedule under which outpatient medical services will be paid, and disputes will arise between the providers and payers regarding the payment of such fees. The emergency adoption of the proposed regulations is necessary to prevent disputes and litigation, and to provide a clear payment system for outpatient medical services.

Amended Labor Code § 5307.1 mandates that pharmacy services rendered on or after January 1, 2004 must be paid at 100 percent of the fees prescribed in the relevant Medi-Cal payment system. The Administrative Director finds this provision in the statute to be self-executing. To assist providers and payers in determining the correct fees for pharmaceuticals, the Division will post Medi-Cal rates on its Internet website.

The Administrative Director has therefore determined that the emergency adoption of the proposed regulations is necessary for the immediate preservation of the public peace, health and safety or general welfare.

**Authority and Reference**

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in the Administrative Director by Labor Code Sections 127, 133, 4603.5, 5307.1, 5307.3, 5307.6, and 5318.

Reference is to Labor Code Sections 139.2, 4061, 4061.5, 4062, 4600, 4603.2, 4620, 4621, 4622, 4625, 4628, 4650, 5307.1, 5307.6, 5318, and 5402.

**Informative Digest**

These regulations are required by a legislative enactment - Statutes of 2003, Chapter 639.

Section 5307.1 of the Labor Code, as amended by Senate Bill 228, requires the Administrative Director to adopt and revise periodically an official medical fee schedule that establishes, except for physician services, the reasonable maximum fees paid for all medical services rendered in workers' compensation cases. Except for physician services, all fees in the adopted schedule must be in accordance with the fee-related structure and rules of the relevant Medicare (administered by the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services) and Medi-Cal payment systems.

Beginning January 1, 2004, and continuing until the above Medicare-based fee schedule is adopted, the maximum reasonable fees for medical services (except for physician services) must be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services. Services paid at this rate include, but are not limited to, hospital inpatient services and services performed in an ambulatory surgical center or hospital outpatient department. The maximum reasonable fee for pharmacy and drug services that are not otherwise covered by a Medicare fee schedule payment for facility services must be 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Fees for medical services and pharmacy services and drugs shall be adjusted to conform to any relevant change in the Medicare and Medi-Cal payment systems.

For the Calendar Years 2004 and 2005 the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent. The Administrative Director has the discretion to reduce individual medical procedures (reflected in the Fee Schedule by separate CPT codes) by amounts different than five percent, but in no event shall a procedure be reduced to an amount that is less than that paid by the current Medicare payment system for the same procedure.

Prior to the adoption of the Medicare-based fee schedule, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or for a pharmacy service or drug not covered by a Medi-Cal payment system, the maximum reasonable fee must not exceed the fee specified in the existing Official Medical Fee Schedule.

The Administrative Director now proposes to adopt administrative regulations governing payment under the Official Medical Fee Schedule for medical services rendered on or after January 1, 2004. These proposed regulations implement, interpret, and make specific Section 5307.1 of the Labor Code as follows:

**1. Section 9789.10**

This section provides definitions for key terms relating to physician services rendered on or after January 1, 2004 to ensure that their meaning will be clear to the regulated public. The key terms include:

(a) "Basic value" is defined to identify the value unit for an anesthesia procedure that used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

(b) "CMS" is defined to identify the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(c) "Conversion factor," or "CF," is defined to clarify the factor that is multiplied by the listed relative value unit of each individual procedure code in the Official Medical Fee Schedule to determine the maximum reimbursable physician fee. The conversion factor is necessary to calculate the 5% reduction in fees for physician services rendered on or after January 1, 2004, as mandated by Labor Code § 5307.1(k) and implemented by Section 9789.11.

(d) "CPT®" is defined to identify the licensed procedure coding system created by the American Medical Association and utilized in the Official Medical Fee Schedule.

(e) "Medicare rate" is defined as the Calendar Year 2004 physician fee schedule established by CMS. As mandated by amended Labor Code § 5307.1(k), the Medicare rate is used as the base by which the 5% reduction in physician fees will be determined.

(f) "Modifying units" is defined to identify the anesthesia modifiers and qualifying circumstances that are used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

(g) "Official Medical Fee Schedule" is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered on or after January 1, 2004. The Official Medical Fee Schedule consists of proposed Article 5.1 of Chapter 4.5, Title 8, California Code of Regulations (commencing with Section 9789.10).

(h) "Official Medical Fee Schedule 2003" (or "OMFS 2003") is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered *before* January 1, 2004. The Official Medical Fee Schedule 2003 was adopted pursuant to Labor Code § 5307.1, in effect on December 31, 2003.

(i) "Percent reduction calculation" is defined to clarify the factor that is to be used for the purpose of applying the percentage reduction in fees for physician services rendered on or after January 1, 2004, as mandated by amended Labor Code § 5307.1(k) (effective January 1, 2004) and implemented by Section 9789.11.

(j) "Physician services" is defined to identify the medical treatment procedures whose maximum reimbursable fees, set forth in the Official Medical Fee Schedule 2003, are subject to the 5% reduction mandated by Labor Code § 5307.1(k) and implemented by Section 9789.11.

(k) "RVU" is defined to identify the relative value unit for a particular procedure, set forth in the Official Medical Fee Schedule 2003, which is used to determine the maximum reimbursable fee for a physician service.

(*l*) "Time value" is defined to identify the unit of time indicating the duration of an anesthesia procedure, set forth in the Official Medical Fee Schedule 2003, which is used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

**2. Section 9789.11**

This section sets forth the formula for determining the maximum reimbursable fees for physician services rendered on or after January 1, 2004. Amended Labor Code § 5307.1(k) requires that such fees, set forth in the Official Medical Fee Schedule 2003, be reduced by 5%. However, the Administrative Director has the discretion to adjust individual procedure codes by different amounts, provided that no resulting fee drops below the current Medicare rate for the same procedure.

(a) This subdivision provides that, except for the "General Information and Instructions" section, the ground rules set forth in the Official Medical Fee Schedule 2003 are applicable to physician services rendered on or after January 1, 2004. A new "General Information and Instructions" section is incorporated by reference.

(b) This subdivision establishes that for physician services rendered on or after January 1, 2004, the maximum reimbursable fees for each procedure set forth in the Official Medical Fee Schedule 2003 shall be reduced up to 5%, except for procedures that are reimbursed at or below the current Medicare rate.

(c) For the convenience of the regulated public, this subdivision consists of a table, "Table A - OMFS Physician Services Fees for Services Rendered on or after January 1, 2004," incorporated by reference, setting forth each individual procedure code, its corresponding relative value, conversion factor, assigned percent reduction calculation (between 0 and 5.0%), and maximum reimbursable fee.

(d) This subdivision sets forth the formulas for determining the 5% reduction in maximum reimbursable fees for physician and anesthesia services. For physician services, the relative value unit for each procedure code is multiplied by the applicable conversion factor, which is then multiplied by the assigned percent reduction calculation (between 0 and 5%) to produce the maximum reimbursement fee before the application of the OMFS 2003 ground rules. For anesthesia services, the base unit for each procedure is added to a modifying unit (if any) and time value, and then multiplied by the conversion factor × 95%.

(e) This subdivision identifies the physician service procedure codes in the Pathology and Laboratory section of the OMFS 2003 that will be subject to the 5% reduction in maximum reimbursable fees required by amended Labor Code § 5307.1 and implemented by Section 9789.11.

**3. Section 9789.20**

In compliance with amended Labor Code §5307.1 (effective January 1, 2004), Section 9789.20 to 9789.24 sets forth the general rules pertaining to the Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule. The regulation sets forth that the Inpatient Hospital Fee Schedule applies to services with a date of discharge on or after January 1, 2004, that the schedule will be adjusted to conform to relevant changes in the Medicare payment schedule no later than 60 days after the effective date of those changes, and that updates will be posted on the Division's website.

**4. Section 9789.21**

Amended Labor Code § 5301.7 provides that all fees by a hospital for inpatient services shall be in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. This regulation sets forth the definitions of terms used in the inpatient fee schedule regulations and the formulas needed in order to determine the maximum payment for medical services.

**5. Section 9789.22**

Amended Labor Code 5301.7 provides that all fees by a hospital for inpatient services shall be in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. This regulation provides the basic procedures for the payment of inpatient services: the formula to determine the maximum payment for inpatient medical services, the requirement for health facilities to provide specific information in their bills to allow payers to determine the maximum payment, the formula for cost outlier cases, an exception for implantable hardware, a new technology pass-through, a modified factor for sole community hospitals, an explanation of how payment for transfers will be calculated, exemptions for certain types of hospitals, and the procedure for a request for redetermination.

**6. Section 9789.23**

This section is a table that provides the Inpatient Hospital Composite Factors and Hospital Specific Outlier Factors.

**7. Section 9789.24**

This section is a table that provides the DRGs (diagnosis related groups), relative weights and geometric length of stay.

**8. Section 9789.30**

This section provides definitions for key terms relating to medical services provided by hospital outpatient departments and ambulatory surgical centers on or after January 1, 2004. The key terms include:

(a) "Adjusted Conversion Factor" is defined to identify CMS' conversion factor for 2003 of 52.151 x the market basket inflation factor of 1.034 x (0.4 + (0.6 x wage index)).

(b) "Ambulatory Payment Classifications (APC)" is defined to identify the list of ambulatory payment classifications of hospital outpatient services used by Centers for Medicare & Medicaid Services (CMS).

(c) "Ambulatory Surgical Center (ASC)" is defined to identify any surgical clinic as defined in the California Health and Safety Code Section 1204 (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4.

(d) "Annual Utilization Report of Specialty Clinics" is defined to identify the Annual Utilization Report of Clinics which is filed by February 15 of each year with the Office of Statewide Health Planning and Development by the ASCs as required by Section 127285 and Section 1216 of the Health and Safety Code.

(e) "APC Payment Rate" is defined to identify CMS' hospital outpatient prospective payment system rate for Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(f) "APC Relative Weight" is defined to identify CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(g) "CMS" is defined to identify the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(h) "Cost to Charge Ratio for ASC" is defined as the ratio of the facility's total operating costs to total gross charges during the preceding calendar year.

(i) "Cost to Charge Ratio for Hospital Outpatient Department" is defined to identify the hospital cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments.

(j) "HCPCS" is defined to identify CMS' Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA's) Physician "*Current Procedural Terminology*" Fourth Edition, (CPT-4) codes, alphanumeric codes, and related modifiers.

(k) "HCPCS Level I Codes" is defined to identify the AMA's CPT-4 codes and modifiers for professional services and procedures.

(l) "HCPCS Level II Codes" is defined to identify the national alphanumeric codes and modifiers maintained by CMS for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(m) "Health Facility" is defined to identify any facility as defined in Section 1250 of the Health and Safety Code.

(n) "Hospital Outpatient Department" is defined to identify any hospital outpatient department as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act.

(o) "Hospital Outpatient Department Services" is defined to refer to any hospital outpatient department as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act.

(p) "Market Basket Inflation Factor" is defined to identify the market basket percentage increase determined by CMS for FY 2004, 3.4%, as set forth in the Federal Register on August 1, 2003, Volume 68, at page 45346.

(q) "Outpatient Prospective Payment System (OPPS)" is defined to identify Medicare's payment system for outpatient services at hospitals. These outpatient services are classified according to a list of ambulatory payment classifications (APCs).

(r) "Total Gross Charges" is defined as the facility's total usual and customary charges to patients, and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

(s) "Total Operating Costs" is defined as the direct cost incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs.

(t) "Wage Index" is defined to identify CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal

Register on November 7, 2003, Volume 68, No. 216, Addenda H through J, pages 63682 through 63690.

(u) "Workers' Compensation Multiplier" means the 120% Medicare multiplier required by Labor Code § 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

**9. Section 9789.31**

In this section the Administrative Director adopts and incorporates by reference the following standards:

(a) In this subdivision the Administrative Director incorporates by reference, the Centers for Medicare & Medicaid Services (CMS) 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690 as follows:

(1) Addendum A, "List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2004."

(2) Addendum B, "Payment Status by HCPCS Code and Related Information Calendar Year 2004."

(3) Addendum D1, "Payment Status Indicators for Hospital Outpatient Prospective Payment System."

(4) Addendum D2, "Code Conditions."

(5) Addendum E, "CPT Codes Which Would Be Paid Only As Inpatient Procedures."

(6) Addendum H, "Wage Index For Urban Areas"

(7) Addendum I, "Wage Index For Rural Areas"

(8) Addendum J, "Wage Index For Hospitals That Are Reclassified."

(b) In this subdivision the Administrative Director incorporates by reference the American Medical Associations' Physician "*Current Procedural Terminology*," 2004 Edition.

(c) In this subdivision the Administrative Director incorporates by reference CMS' 2004 Alphanumeric *"Healthcare Common Procedure Coding System* (HCPCS)*."*

**10. Section 9789.32**

This Section sets forth the applicability of the hospital outpatient department and surgical center fee schedule.

(a) This subdivision provides that Sections 9789.30 through 9789.38 are applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after January 1, 2004. The subdivision defines emergency room visits based on CPT codes 99281-99285 and surgical procedures based on CPT codes 10040-69990. The subdivision further provides that a facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. Subparts (a)(1) through (a)(3) set forth when a supply, drug, device, blood product and biological are considered an integral part of an emergency room visit or surgical procedure.

(b) This subdivision provides that Sections 9789.30 through 9789.38 apply to any hospital outpatient department as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204(b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis.

(c) This subdivision provides that the maximum allowable fees for services and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in Section 9789.33(a) for a facility fee payment will be determined pursuant to subparts (c)(1) through (c)(7).

(d) This subdivision provides that only hospitals may charge or collect a facility fee for emergency room visits. It further provides that only hospitals and ambulatory surgical centers as defined in Section 9789.30(c) and Section 9789.30(m) may charge or collect a facility fee for surgical services provided on an outpatient basis.

(e) This subdivision provides that hospital outpatient departments and ambulatory surgical centers will not be reimbursed for procedures on the inpatient only list, Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The subdivision further provides that the pre-authorization must be provided by an authorized agent of the claims administrator to the provider, and the fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(f) This subdivision provides that critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.

**11. Section 9789.33**

This section sets forth the formulas for maximum allowable payment for services rendered on or after January 1, 2004 by hospital outpatient departments and ambulatory surgical centers.

(a) This subdivision provides the formula to determine the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed on or after January 1, 2004 at a hospital outpatient department or at an ambulatory surgical center. This subdivision further provides that a 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.

(1) This subpart provides that the formula to determine the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed on or after January 1, 2004 at a hospital outpatient department or at an ambulatory surgical center for procedures with codes with status code indicators "S", "T" or "V" is: (APC relative weight x $52.151) x (.40 +.60 x applicable wage index) x inflation factor of 1.034 x 1.22.

(A) This subpart provides that Table A in Section 9789.34 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. It further provides that the maximum payment for ASCs and non-listed hospitals can be determined using the following formula: APC relative weight x adjusted conversion factor x 1.22.

(B) This subpart provides that Table B in Section 9789.35 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. It further provides that the maximum payment for the listed hospitals can be determined using the following formula: APC relative weight x adjusted conversion factor x 1.22.

(2) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes for drugs and biologicals with status code indicator "G" is APC payment rate x 1.22.

(3) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes with status code indicator "H" is documented paid costs, net of discounts and rebates, plus 10%.

(4) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes for drugs and biologicals with status code indicator "K" is APC payment rate x 1.22.

(b) This subdivision provides for an alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a).

(1) This subpart provides that the standard payment formulas pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a).

(A) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes with status code indicators "S", "T" or "V" is: (APC relative weight x $52.151) x (.40 +.60 x applicable wage index) x inflation factor of 1.034 x 1.20.

(B) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes for drugs and biologicals with status code indicator "G" is APC payment rate x 1.20.

(C) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes with status code indicator "H" is documented paid costs, net of discounts and rebates, plus 10%.

(D) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes for drugs and biologicals with status code indicator "K" is APC payment rate x 1.20.

(2) This subpart provides that the additional payment formula for a high cost outlier case pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) is [(Facility charges x cost-to-charge ratio) - standard payment x 2.6)] x .50.

(3) This subpart provides that in determining the additional payment, the facility's charges and standard payment for devices with status code indicator "H" shall be excluded from the computation.

(c) This subdivision sets forth the requirements which must be met in order to qualify for the alternative payment methodology.

(1) This subpart provides that the facility that is seeking reimbursement for high cost outlier cases is required to file a DWC Form 15 "Election for High Cost Outlier," contained in Section 9789.37. The completed form must be filed before March 1 of each year. The election becomes effective on April 1 of the same year and remains effective for a one-year period.

(2) This subpart provides that if the facility does not file a timely election satisfying

the requirements set forth in this subdivision and Section 9789.37, payment is determined under subdivision (a).

(3) This subpart provides that if a hospital does not participate under Medicare, the maximum allowable fees applicable are determined under subdivision (a).

(4) This subpart requires that the cost-to-charge ratio applicable to a hospital participating in the Medicare program are determined based on the hospital's cost-to-charge used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 C.F.R. § 419.43(d), which is incorporated by reference and contained in Section 9789.38 - Appendix X. This subpart further provides that the cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed is to be included on the hospital's election form.

(5) This subpart provides that the cost-to-charge ratio applicable to an ambulatory surgery center is the ratio of the facility's total operating costs to total gross charges during the preceding calendar year. The facility's election form as contained in Section 9789.37 must include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility's election form shall further include the facility's total operating costs during the preceding calendar year, the facility's total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to audit by the Division of Workers' Compensation.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website or upon request to the Administrative Director.

(6) This subpart provides that before April 1 of each year the AD will post a listing of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The subpart further provides that the list shall be posted on the Division of Workers' Compensation or is available upon request to the Administrative Director.

(d) This subdivision provides that the OPPS rules (42 C.F.R § 419.44 and Status Indicators in Addendum A) regarding reimbursement for multiple procedures are incorporated by reference as set forth in Section 9789.38 - Appendix X.

(e) This subdivision provides that the OPPS rules in 42 CFR §§ 419 62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and

biologicals are incorporated by reference, as contained in Section 9789.38 - Appendix X, except that payment for these items is made pursuant to subdivisions (a) or (b) as applicable.

(f) This subdivision provides that the payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b), which is incorporated by reference, as contained in Section 9789.38 Appendix X. This subdivision further provides that all of the cost items specified in 42 C.F.R. § 419.2(c)1-6 are included in the maximum allowable payment rate and are incorporated by reference as contained in Section 9789.38 Appendix X.

(g) This subdivision provides that the maximum allowable fees are determined without regard to the provisions in 42 C.F.R. § 419.70 as contained in Section 9789.38 - Appendix X.

**12. Section 9789.34**

This Section contains Table A, containing an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. By using Table A, the ASCs and non-listed hospitals can determine the maximum payment rate based on the following formula: APC relative weight x adjusted conversion factor x 1.22.

**13. Section 9789.35**

This Section contains Table B, listing an "adjusted conversion factor" which incorporates the standard conversion factor, wage index, and inflation factor. By using Table B, the listed hospitals can determine the maximum payment rate based on the following formula: APC relative weight x adjusted conversion factor x 1.22.

**14. Section 9789.36**

This Section provides that Sections 9789.30 through 9789.38 will be adjusted to conform to any relevant changes in the Medicare payment system as required by law. It further provides that the Administrative Director will determine the effective date of the change and issue an order informing the public of the change and the effective date, and the order will be posted on the Division's Internet Website.

**15. Section 9789.37**

This Section sets forth the form which will be used when electing to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) in lieu of the maximum allowable fees set forth pursuant to Section 9789.33(a). The facility electing to elect the high cost outlier payment methodology must file this form with the Administrative Director by March 1 of each year providing the requested information. The hospital outpatient departments must include in the form the cost-to-charge ratio being used by the Medicare fiscal intermediary to determine high cost outlier payments. The ASCs shall include in the form the

facility's total operating costs during the preceding calendar year, the facility's total gross charges for the preceding calendar year. The facility's election form shall further include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to audit by the Division of Workers' Compensation.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website or upon request to the Administrative Director. The facility's election form shall further include a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information and attachment(s). Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC.

**16. Section 9789.38**

This Section sets forth the Medicare federal regulations which have been incorporated by reference and/or referred to in the outpatient fee schedule regulations in numerical order.

**17. Section 9789.40**

This section provides that the fees for pharmacy services rendered on or after January 1, 2004 will be paid at 100% of the fees prescribed in the relevant Medi-Cal payment system. The Division will provide the means by which providers and payers can access current and past Medi-Cal rates.

**18. Section 9789.50**

This section provides that the maximum reimbursable fee for pathology and laboratory services rendered on or after January 1, 2004 shall not exceed 120% of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule applicable to California. The section identifies specific codes in the Special Services and Reports section of the OMFS 2003 that are eliminated based on the change to the CMS fee schedule.

**19. Section 9789.60**

This section provides that for services, equipment, or good provided on or after January 1, 2004, the maximum reimbursable fee for durable medical equipment, supplies and materials, Orthotics, prosthetics, and miscellaneous supplies and services shall not exceed 120% of the rate for the same procedure code in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, applicable to California and as updated in the October 2003 quarterly update. The section identifies specific codes in the Special Services and Reports section of the OMFS 2003 that are eliminated based on the change to the CMS fee schedule.

**20. Section 9789.70**

This section provides that the maximum reimbursable fee for ambulance services rendered on or after January 1, 2004 shall not exceed 120% of the applicable fee set forth in CMS' Ambulance Fee Schedule, applicable to California.

**21. Section 9789.80**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for skilled nursing facilities.

**22. Section 9789.90**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for home heath care.

**23. Section 9789.100**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for outpatient renal dialysis.

**24. Section 9789.110**

Pursuant to amended Labor Code § 5307.1(g), this section provides that the OMFS shall be adjusted to reflect any relevant changes in the Medicare and Medi-Cal payment systems. The Administrative Director shall determine the effect date of the change and issue an order informing the public of the change and the effective date. Any order issued by the Administrative Director under this section must be posted on the Division of Workers' Compensation Internet Website.

## MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

There are no other matters prescribed by statute applicable to the Division of Workers' Compensation or to any specific regulation or class of regulations.

## MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Administrative Director has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district. The California Supreme Court has determined that an increase in workers' compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. See County of Los Angeles v. State of California (1987) 43 Cal.3d 46. The potential costs imposed on all public agency employers and payors by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payors, both public and private, and

not uniquely to local governments.

**FISCAL IMPACTS**

Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The regulations proposed herein may, from time to time, impose costs on local agencies and school districts. Any such costs, however, will be non-discretionary because the requirement that every employer reimburse physicians or other providers for medical treatment for industrially injured employees is a statutory obligation. Furthermore, any such costs are non-reimbursable because the requirement on employers to reimburse health care providers for medical treatment for industrially injured employees is not unique to local agencies or school districts and applies to all employers alike, public and private, including the State of California.

Other nondiscretionary costs/savings imposed upon local agencies: None. To the extent that local agencies and school districts are self-insured employers who must reimburse physicians or other providers for medical treatment for industrially injured employees, they will be subject to the same cost impacts as all other employers in the state.

Costs or savings to state agencies or costs/savings in federal funding to the State: No impact on any federal funding. The proposed regulations may have cost and savings impacts on State agencies to the extent that the State is an employer, and to the extent that the State may be a provider of medical services.